

<sup>3</sup> The Board notes that, following the March 27, 2018 decision, OWCP received additional evidence. However, the Board’s *Rules of Procedure* provides: “The Board’s review of a case is limited to the evidence in the case record that was before OWCP at the time of its final decision. Evidence not before OWCP will not be considered by the Board for the first time on appeal.” 20 C.F.R. § 501.2(c)(1). Thus, the Board is precluded from reviewing this evidence for the first time on appeal. *Id.*

## **ISSUE**

The issue is whether appellant has met his burden of proof to establish right neck and arm, right lower back, and right leg injuries causally related to an accepted September 11, 2017 employment incident.

## **FACTUAL HISTORY**

On September 14, 2017 appellant, then a 47-year-old cook supervisor, filed a traumatic injury claim (Form CA-1) alleging that on September 11, 2017, while opening a food service door that was stuck, he injured his right neck and arm, right lower right back, and right leg. He did not stop work.

In a September 25, 2017 development letter, OWCP requested that appellant submit additional factual and medical information including a comprehensive medical report from his treating physician regarding how specific work incidents contributed to his claimed injuries. It afforded him 30 days to submit the requested information.

Appellant was treated by Dr. Robert C. Smith, a Board-certified family practitioner, on September 18 and 25, and October 2, 2017, for cervical pain and right upper and lower extremity pain. He reported that on September 11, 2017 he attempted to open a food service door that was stuck, which caused pain in his cervical region, right upper extremity, and lumbar region radiating into his right lower extremity. Appellant was treated in the emergency room and discharged with medications. Findings on examination revealed L5 radiculopathy, weakness of the extensors and intrinsic muscles of the right hand, back pain, decreased range of motion, and radiating pain. Appellant's history noted as significant for an anterior cervical discectomy and fusion surgery. Dr. Smith opined that appellant was totally disabled from work. In an attending physician's report (Form CA-20) dated September 18, 2017, he noted that on September 11, 2017 appellant reported pulling a door at work and injuring his neck, back, and right upper and lower extremity. Dr. Smith diagnosed right L5 radiculopathy and right C6 radiculopathy and checked a box marked "yes" that appellant's condition was caused or aggravated by an employment activity. He noted that appellant was totally disabled from September 11, 2017. Other work capacity evaluations (Form OWCP-5c) dated September 18 to October 23, 2017, from Dr. Smith noted that appellant was totally disabled from work. Similarly, in duty status reports (CA-17 forms) dated September 18 to October 23, 2017, he diagnosed right L5 radiculopathy and right C6 radiculopathy and noted that appellant was totally disabled for work.

The employing establishment completed a form granting authorization for examination and/or treatment (Form CA-16) on September 18, 2017. On the form Dr. Smith indicated that on September 11, 2017 appellant reported pulling a stuck door at work injuring his neck, back, and right upper and lower extremity. He diagnosed right L5 radiculopathy and right C6 radiculopathy and checked a box marked "yes" that appellant's condition was caused or aggravated by an employment activity. Dr. Smith prescribed steroids, muscle relaxants, pain medication, and ordered diagnostic testing. He noted that appellant was totally disabled from work as of September 11, 2017.

An x-ray of the cervical spine dated September 20, 2017 revealed stable fusion hardware position and spondylitic changes. A lumbar magnetic resonance imaging (MRI) scan dated

September 20, 2017 revealed a large right paracentral disc protrusion/extrusion at L4-5 causing severe central stenosis, associated bilateral foraminal stenosis, moderate-to-severe left lateral recess, and foraminal stenosis at L5-S1 due to disc bulge, facet atrophy, and spondylosis at other levels.

On October 12, 2017 Dr. Erich Wolf, a Board-certified neurosurgeon, treated appellant for low back pain and associated weakness. Appellant reported that, while at work on September 11, 2017, he pulled a door and felt a pop down the right side of his body. His history was significant for an anterior cervical discectomy and fusion performed in January 2014. Findings on examination revealed tenderness of the entire right lumbar spine, low back pain, severe radicular pain, decreased muscle strength, hypoesthesia at L4, L5, and S1, and positive straight leg raising on the right. Dr. Wolf diagnosed intervertebral disc disorders with radiculopathy and right foot drop.

On October 13, 2017 Dr. Wolf performed an emergency right L4-5 microlumbar discectomy with fluoroscopy and diagnosed L4-5 right herniated nucleus pulposus with radiculopathy.

Appellant was treated by Dr. Smith on October 23, 2017 for postoperative follow-up and staple removal. Dr. Smith noted a history of injury and diagnosed spinal stenosis lumbar region, and radiculopathy of the lumbar and cervical regions. Findings on examination revealed back pain, cervical pain, decreased range of motion, muscular weakness, numbness in the right lower extremity, redness around the surgical site, mild cellulitis, and slight exudates from the proximal staple, complicated by cigarette smoking. Appellant remained disabled from work.

By decision dated November 9, 2017, OWCP denied appellant's claim for compensation because the evidence of record was insufficient to establish that the diagnosed medical conditions were causally related to the accepted employment incident.

Appellant was treated by Dr. Smith in a follow up on November 6 and 15, 2017. Dr. Smith noted a history of injury on September 11, 2017 and prior disc herniation surgery. Appellant presented with right lower leg pain and loss of function, chronic cervical pain, and weakness in the right upper extremity. Dr. Smith diagnosed spinal stenosis and radiculitis of the lumbar and cervical region. He opined that appellant's complaints were consistent with the mechanism of injury that occurred on September 11, 2017. Dr. Smith further noted that the progressive loss of motor function was consistent with the mechanism of injury and the clinical findings. He advised that appellant was totally disabled. In a work capacity evaluation (OWCP-5c) dated November 15, 2017, Dr. Smith noted that appellant was totally disabled from work. Similarly, in a duty status report (Form CA-17) dated November 15, 2017, he diagnosed right L5 radiculopathy and right C6 radiculopathy and noted that appellant was totally disabled.

On December 5, 2017 appellant was treated by a nurse practitioner post right L4-5 lumbar microdiscectomy. The nurse practitioner diagnosed right drop foot and referred him for physical therapy.

In an amended decision dated December 19, 2017, OWCP denied appellant's claim for compensation because the evidence of record was insufficient to establish that the diagnosed medical conditions were causally related to the accepted employment incident.

Appellant requested reconsideration on December 27, 2017.

In a December 18, 2017 report, Dr. Smith diagnosed spinal stenosis and radiculitis of the lumbar and cervical region. He found that the report of injury and the mechanism thereof, was “consistent with clinical findings and is consistent with the transfer of energy that created the pathology in this patient.” Dr. Smith opined that this was evidence that the injury occurred from the actions that the patient described. In work capacity evaluations (Form OWCP-5c) dated December 18, 2017 to January 19, 2018, he noted that appellant was totally disabled from work. Similarly, in duty status reports (CA-17 forms) dated December 18, 2017 to January 19, 2018, Dr. Smith diagnosed right L5 and C6 radiculopathy and noted that appellant was totally disabled from work. In other reports dated January 5 to 19, 2018, he treated appellant in follow ups for pain and numbness in the lumbar spine and left lower extremity, weakness and changes in sensation of his left lower extremity. Dr. Smith diagnosed spinal stenosis and radiculopathy of the lumbar and cervical region and recommended a new MRI scan of the lumbar spine. He continued to opine that appellant was disabled from work. On February 26, 2018 Dr. Smith noted appellant’s complaints of progression of the left L5 radiculopathy with changes in sensation. Appellant remained totally disabled. On March 14, 2018 Dr. Smith released appellant to return to work light duty. Also submitted were toxicology reports dated October 2, 2017 to March 5, 2018.

By decision dated March 27, 2018, OWCP denied modification of its December 19, 2017 decision.

### **LEGAL PRECEDENT**

A claimant seeking benefits under FECA<sup>4</sup> has the burden of proof to establish the essential elements of his or her claim by the weight of the reliable, probative, and substantial evidence, including that an injury was sustained in the performance of duty as alleged, and that any specific condition or disability claimed is causally related to the employment injury.<sup>5</sup>

To determine if an employee sustained a traumatic injury in the performance of duty, OWCP begins with an analysis of whether “fact of injury” has been established. Generally, fact of injury consists of two components that must be considered in conjunction with one another. The first component is whether the employee actually experienced the employment incident that allegedly occurred.<sup>6</sup> The second component is whether the employment incident caused a personal injury.<sup>7</sup> An employee may establish that an injury occurred in the performance of duty as alleged, but fail to establish that the disability or specific condition for which compensation is being claimed is causally related to the injury.<sup>8</sup>

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<sup>4</sup> *Id.*

<sup>5</sup> 20 C.F.R. § 10.115(e), (f); *see Jacquelyn L. Oliver*, 48 ECAB 232, 235-36 (1996).

<sup>6</sup> *Elaine Pendleton*, 40 ECAB 1143 (1989).

<sup>7</sup> *T.H.*, 59 ECAB 388, 393 (2008); *John J. Carlone*, 41 ECAB 354 (1989).

<sup>8</sup> *Shirley A. Temple*, 48 ECAB 404, 407 (1997).

Causal relationship is a medical question that generally requires rationalized medical opinion evidence to resolve the issue.<sup>9</sup> A physician's opinion on whether there is causal relationship between the diagnosed condition and the implicated employment factor(s) must be based on a complete factual and medical background.<sup>10</sup> Additionally, the physician's opinion must be expressed in terms of a reasonable degree of medical certainty, and must be supported by medical rationale, explaining the nature of the relationship between the diagnosed condition and appellant's specific employment factor(s).<sup>11</sup>

In any case where a preexisting condition involving the same part of the body is present and the issue of causal relationship therefore involves aggravation, acceleration, or precipitation, the physician must provide a rationalized medical opinion that differentiates between the effects of the work-related injury or disease and the preexisting condition.<sup>12</sup>

### ANALYSIS

The Board finds that appellant has not met his burden of proof to establish right neck and arm, right lower back, and right leg injuries causally related to an accepted September 11, 2017 employment incident.

In support of his claim, appellant submitted reports from Dr. Smith dated September 18 to October 23, 2017. Dr. Smith noted that appellant reported that, while attempting to open a food service door at work on September 11, 2017, he felt pain in his cervical region, right upper extremity, and lumbar region radiating into the right lower extremity. He repeated the history of injury as reported by appellant, but he did not provide his own opinion regarding whether the diagnosed conditions were work related. The mere recitation of patient history does not suffice for purposes of establishing causal relationship between a diagnosed condition and the employment incident.<sup>13</sup> Without explaining physiologically how the accepted employment incident caused or contributed to the diagnosed conditions, the physician's reports are of limited probative value.<sup>14</sup>

In a September 18, 2017 attending physician's report (Form CA-20), Dr. Smith noted that appellant reported pulling a door at work which was stuck injuring his neck, back, right upper extremity and right lower extremity. He diagnosed right L5 radiculopathy and right C6 radiculopathy and checked a box marked "yes" indicating that appellant's condition was caused or aggravated by an employment activity. The Board has held that when a physician's opinion on causal relationship consists only of checking "yes" to a form question, without explanation or

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<sup>9</sup> *Robert G. Morris*, 48 ECAB 238 (1996).

<sup>10</sup> *I.J.*, 59 ECAB 408 (2008); *Victor J. Woodhams*, 41 ECAB 345, 352 (1989).

<sup>11</sup> *Victor J. Woodhams*, *id.*

<sup>12</sup> Federal (FECA) Procedure Manual, Part 2 -- Claims, *Causal Relationship*, Chapter 2.805.3e (January 2013).

<sup>13</sup> *See J.G.*, Docket No. 17-1382 (issued October 18, 2017).

<sup>14</sup> *See A.B.*, Docket No. 16-1163 (issued September 8, 2017).

rationale, that opinion is of diminished probative value and is insufficient to establish a claim.<sup>15</sup> Therefore, this report is insufficient to establish appellant's claim.

Work capacity evaluations (OWCP-5c) and duty status reports (CA-17 forms) dated September 18, 2017 to January 19, 2018, from Dr. Smith diagnosed right L5 radiculopathy and right C6 radiculopathy and noted that appellant was totally disabled. However, Dr. Smith did not specifically address whether the September 11, 2017 employment incident caused or aggravated a diagnosed medical condition. The Board has held that medical evidence that does not offer an opinion regarding the cause of an employee's condition is of no probative value on the issue of causal relationship.<sup>16</sup> Therefore, these reports are insufficient to meet appellant's burden of proof.

Other reports from Dr. Smith dated November 6 and 15, 2017 diagnosed spinal stenosis and radiculopathy of the lumbar and cervical region and noted that appellant's progressive loss of motor function was consistent with the mechanism of injury that occurred on September 11, 2017. Similarly, on December 18, 2017 Dr. Smith diagnosed spinal stenosis and radiculopathy of the lumbar and cervical region and indicated that the report of this injury and the mechanism thereof was consistent with clinical findings and consistent with the transfer of energy that created the pathology. Dr. Smith noted that this was evidence that the injury occurred from the actions that the patient described. The Board finds that, although he supported causal relationship, he did not provide medical rationale explaining the basis of his conclusory opinion regarding the causal relationship between appellant's lumbar and cervical conditions and the September 11, 2017 work incident. Dr. Smith did not explain the process by which pulling on a food service door would cause or aggravate the diagnosed conditions and why the conditions would not be related to nonwork-related conditions like age-related degenerative changes. Medical rationale was particularly necessary in this matter given that appellant had a prior anterior cervical discectomy and fusion performed on January 2014.<sup>17</sup> As the opinion of appellant's physician regarding causal relationship was conclusory and unexplained, it was insufficient to meet appellant's burden of proof.

Other medical evidence of record, including an x-ray of the cervical spine dated September 20, 2017, an MRI scan dated September 20, 2017, and toxicology reports are of limited probative value as they fail to provide a physician's opinion on the causal relationship between appellant's work incident and his diagnosed cervical and lumbar conditions.<sup>18</sup> Thus, this evidence is insufficient to meet appellant's burden of proof.

Appellant was treated by Dr. Wolf on October 12, 2017 who diagnosed L4-5 right herniated nucleus pulposus with radiculopathy. He reported that, while at work on September 11, 2017, he pulled a door and felt a pop down the right side of his body. Dr. Wolf performed an emergency right L4-5 microlumbar discectomy with fluoroscopy on October 13, 2017. While he repeated the history of injury as reported by appellant, he did not provide his own opinion

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<sup>15</sup> *D.D.*, 57 ECAB 734 (2006); *Sedi L. Graham*, 57 ECAB 494 (2006).

<sup>16</sup> *See L.B.*, Docket No. 18-0533 (issued August 27, 2018); *D.K.*, Docket No. 17-1549 (issued July 6, 2018).

<sup>17</sup> *See P.M.*, Docket No. 18-0543 (issued November 7, 2018). *Michael S. Mina*, 57 ECAB 379 (2006).

<sup>18</sup> *Id.*

regarding whether his condition was work related.<sup>19</sup> Therefore, these reports are insufficient to meet appellant's burden of proof.

On December 5, 2017 appellant was treated by a nurse practitioner who diagnosed right drop foot and surgical aftercare and referred him for physical therapy. The Board has held that treatment notes signed by nurse practitioners<sup>20</sup> are not considered medical evidence as this provider is not a physician under FECA<sup>21</sup> and is not competent to render a medical opinion under FECA. Thus, this evidence is insufficient to meet appellant's burden of proof.

Consequently, the Board finds that appellant has not met his burden of proof to establish that the accepted September 11, 2017 work incident caused or aggravated a diagnosed medical condition.<sup>22</sup>

Appellant may submit new evidence or argument with a written request for reconsideration to OWCP within one year of this merit decision, pursuant to 5 U.S.C. § 8128(a) and 20 C.F.R. §§ 10.605 through 10.607.

### **CONCLUSION**

The Board finds that appellant has not met his burden of proof to establish right neck and arm, right lower back, and right leg injuries causally related to the accepted September 11, 2017 employment incident.

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<sup>19</sup> *Supra* note 15.

<sup>20</sup> *Paul Foster*, 56 ECAB 208 (2004) (where the Board found that a nurse practitioner is not a "physician" pursuant to FECA).

<sup>21</sup> *See David P. Sawchuk*, 57 ECAB 316, 320 n.11 (2006) (lay individuals such as physician assistants, nurses, and physical therapists are not competent to render a medical opinion under the FECA); 5 U.S.C. § 8101(2) (this subsection defines a "physician" as surgeons, podiatrists, dentists, clinical psychologists, optometrists, chiropractors, and osteopathic practitioners within the scope of their practice as defined by State law).

<sup>22</sup> The record contains a Form CA-16 signed by the employing establishment official on September 18, 2017. When an employing establishment properly executes a CA-16 form which authorizes medical treatment as a result of an employee's claim for an employment-related injury, the CA-16 form creates a contractual obligation, which does not involve the employee directly, to pay for the cost of the examination or treatment regardless of the action taken on the claim. The period for which treatment is authorized by a CA-16 form is limited to 60 days from the date of issuance, unless terminated earlier by OWCP. *See* 20 C.F.R. § 10.300(c); *Tracy P. Spillane*, 54 ECAB 608 (2003). The record is silent as to whether OWCP paid for the cost of appellant's examination or treatment for the period noted on the form.

**ORDER**

**IT IS HEREBY ORDERED THAT** the March 27, 2018 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: December 28, 2018  
Washington, DC

Christopher J. Godfrey, Chief Judge  
Employees' Compensation Appeals Board

Patricia H. Fitzgerald, Deputy Chief Judge  
Employees' Compensation Appeals Board

Valerie D. Evans-Harrell, Alternate Judge  
Employees' Compensation Appeals Board